Fertility Agents (Injectable Gonadotropins Only) Prior Authorization Request Form

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Mail Order Pharmacy (TMOP). Express Scripts is the TMOP contractor for DoD.

Your patient receives their prescription drug benefit from the Department of Defense (DoD). The DoD prescription drug benefit plan requires that we review certain requests for coverage with the prescribing physician. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage can be provided. **Before giving the prescription to the patient, please make a copy of this form, complete the following questions and give the completed form, along with the prescription, to the patient. Please instruct the patient to send this completed form, along with the prescription, to Express Scripts for processing.**

If Express-Scripts already has your patient's prescription and has requested that you complete this form, the completed form may be faxed to: (877) 895-1900 (toll-free) or (602) 586-3911 (commercial). A copy of this form and explanations of the underlying clinical rationale and criteria for approval are available at www.pec.ha.osd.mil/PA_Criteria_and_forms.htm.

Drug for which Prior Authorization is requested:

- ☐ **Follitropin alfa (Gonal-F®)**
- ☐ **Follitropin beta (Follistim®)**
- ☐ **Urofollitropin (Fertinex®, Bravelle®)**
- ☐ **Menotropins (Humegon®, Pergonal®, Repronex®)**

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Member # _____ Phone #: _____

Secure Fax #:

Step 2 **Please complete patient specific information**

Is the patient male?

If yes, prior authorization criteria do not apply. Male patients who are being treated with injectable gonadotropins are not required to submit a prior authorization form to the TMOP. ☐ Yes ☐ No

If no, please proceed to Step 3.

Step 3 **Please complete the clinical assessment:**

Is the fertility agent being prescribed for use in conjunction with a noncoital reproductive technology, including but not limited to artificial insemination, in vitro fertilization, or gamete intrafallopian transfer?

If no, benefit is approved for 1 year. Drug benefit coverage is limited to 3600 IU per 30 days with no refills. ☐ Yes ☐ No

If yes, benefit coverage is not approved. The TRICARE family planning benefit outlined in the Code of Federal Regulations does not include services and supplies related to noncoital reproductive technologies.

Step 4 **Please sign and date:**

_____ _____

Prescriber Signature Date

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